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PUBLIC HEALTH AND HUMAN SERVICES

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DATE: October 13, 2005

TO: Senator John Cobb, Chairman
Legislative Finance Committee

LFC Committee Members

Lois Steinbeck
Senior Fiscal Analyst

FROM: John Chappuis, Deputy Director
on behalf of Joan Miles, Director

RE: The Top 10 Questions – Medicare Modernization Act (MMA)

Per your request, below are the answers to your questions on the memo dated September 30 relating to the MMA changes and the federal Part D program. Please forward this information on to the Legislative Finance Committee members. Thank you.

1. What is the per person base year cost of prescription drugs for dual eligibles that will be used to determine clawback amount and what is the clawback per person base price compared to the most complete 12 month per person prescription drug cost for dual eligibles for the most recent federal calculation and the most recent DPHHS calculation? (Most complete means that claim data is mostly complete.)

The baseline drug cost is a per-member per-month (PMPM) cost figure, rather than a per-person per-year figure. DPHHS has been working extensively with CMS on the baseline clawback amount because the figure will be used for calculation of the monthly clawback payments indefinitely. Over the past several months, DPHHS has identified a few issues that could affect the baseline clawback amount.

First, the MSIS files that CMS is using to calculate the baseline clawback amount do not include all individuals who received retroactive Medicaid eligibility. DPHHS is in the process of determining how the exclusion of these eligibles would impact the

baseline clawback amount. CMS has indicated they will not make any adjustments to the baseline amount, regardless of the size of the impact.

Second, family planning drugs are not correctly identified in the MSIS files for the base--calendar year (CY) 2003. DPHHS has been working to quantify the impact of this discrepancy. CMS has indicated they will not make any adjustments to the baseline amount, regardless of the size of the impact.

In August, CMS verbally notified the department that the methodology they will use to calculate the clawback amounts has changed. DPHHS has yet to receive written notification of the change or a detailed description of the methodology that will be employed. Despite this, DPHHS has persistently worked with CMS in order to learn and replicate the CMS methodology and calculate the baseline amount independently of CMS.

On October 7, 2005 DPHHS received a phone message from Dennis Smith at CMS that the baseline PMPM cost that will be used for our clawback payments is $75.35. This is consistent with the figure we recently calculated when using the updated CMS methodology. However, as stated above, the correct inclusion of retro eligibles and family planning drugs may cause our estimate to differ from the baseline figure provided by CMS, and CMS has stated no adjustments will be made.

2. What would be the clawback payment if it were due for the most recently completed 12-month period? (Most complete means that claim data is mostly complete.)

The clawback payment amounts will be based on the baseline amount trended forward, as well as actual enrollment data beginning in January 2006. Actual enrollment and claims volume after the end of the base year, CY 2003, and before Jan 1, 2006 are irrelevant to the baseline payment that will be due. Based on the above PMPM baseline clawback amount of $75.35, and projected enrollment of 13,818 full benefit duals, the projected clawback payment for Jan 2006 is about $1,040,000. Assuming no growth in the number of full benefit duals, this will be about $12,500,000 per year. Assuming 4% growth in the number of full benefit duals, it will be about $12,750,000 per year.

3. What procedures will DPHHS institute to accept/review/process applications for Part D low-income subsidy determination and automatic Medicaid eligibility determination?

DPHHS developed a policy to comply with federal regulations regarding states' role in low income subsidy determination. The policy is attached and includes the process to screen applicants for Medicaid and Medicare Savings Programs. (See attachment "MedCore Workgroup Policy Number One")

4. Please describe the training that the following field staff/contractors received regarding MMA:

a. Office of Public Assistance eligibility determination staff: Office of Public Assistance eligibility staffs have been trained in the basics of MMA and Part D through:

- Presentations to management by SSA, CMS, and state staff complete with handouts to take back for field staff training;
- Frequent e-mail updates, both state generated and CMS information forwarded;
- Attendance at local SSA/CMS presentations; and
- Regional Policy specialist trainings.

b. State targeted case management staff—DD: On May 25, 2005 Mary Noel provided training to DD case mangers and state staff. Additional training with Mary and case managers is scheduled during the week of Dec. 12, 2005.

c. Contract case managers for Medicaid eligible persons with a mental illness, developmental disability, traumatic brain injury, or physical disability:

AMDD: On October 28, 2005 AMDD is hosting a MET NET for mental health case managers. The panel includes Mary Noel (OPCA), Kimme Evermann (SHIP), and Margaret Souza (Big Sky Rx). We have reserved 19 sites across the state for the 2-hour presentation. This will be followed up in mid-November with a telephone conference call for questions and answers. Handouts for the MET NET will be distributed electronically to the mental health centers prior to the teleconference.

DDP: See 4b above

SLTC: Case managers received training in May at their case management meeting by Jeff Buska as well as a session at the Community Services Conference that was held Sept 21-23 for case managers put on by Kimme Everman. SLTC staff received an overview of the Part D benefits at an all Division staff meeting on October 4th. Presentation was provided by Kimme Everman the SHIP program staff person. This includes Adult Protective Services, Regional Program Officers and Helena staff.

d. SCHIP or SHIP representatives: SCHIP-Mary Noel, DPHHS Office of Planning, Coordination and Analysis, attended a Health Care Resources Bureau staff meeting on August 10, 2005 and provided training about MMA entitled, "Medicare Part D: An Overview". She also provided written materials that were detailed and informative. Additionally, all SHIP counselors/volunteers are attached administratively to an Area Agency on Aging (AAA) and are trained in conjunction with AAA/Aging network staff.

e. Area Agency on Aging (AAA) representatives: The Office on Aging provides an annual Spring training with all the field staff from the AAA's. Beginning in the Spring of 2004, training on MMA and the drug discount cards began. In January 2005, representatives from (8) of Montana's (10) Area Agencies on Aging attended the Health Assistance Partnership conference in Washington, DC; this conference was an MMA training/strategizing opportunity. These representatives returned to their respective areas and shared conference curriculum with colleagues. At the Annual Governor's Conference on Aging in May 2005, MMA general sessions were offered as well as breakout sessions to all the AAA staff, and paid for approximately 100 SHIP counselors to attend the conference so they could get a wide variety of training with regard to Medicare Modernization.

In Summer 2005, Nan Pellegren, our CMS Regional Liaison (Denver) and Kimme Everman presented a series of MMA "Train-the-trainer" events which addressed a foundation of Medicare basics as well as Medicare Part D and Medicare Advantage. These (2) day events were held in Helena, Glendive, Butte, Lewistown and Kalispell. These were open to all AAA staff as well as any other professional who wanted to attend.

This fall, Nan Pellegren, our CMS Regional Liaison (Denver) and Kimme are planning another "Train-the-trainer" series in Helena, Glendive, Miles City, Butte, Lewistown, Kalispell, Bozeman, Great Falls, which would be an intensive training on the Medicare Part D and Medicare Advantage plans. Unfortunately, the Federal funding for this series of events has been rescinded and we are not sure when or if we will be able to do this training.

Additionally, AAA staffs participate in many of the training conference calls which are provided by CMS, Areas on Aging and the Health Assistance Partnership and the Medicare Rights Center. Many do participate and it is considered (informally) continuing education. Kimme also has an extensive e-mail distribution list, which she uses to share all relevant written information she receives.

(Refer to the attachments: "Guidance for Organizations" and "Helps is Here-Training Resources)

5. Please describe the appeals process that DPHHS will administer for complaints arising due to low-income subsidy determination and drug plan administration.

The only time DPHHS would be involved with an appeal due to a low income subsidy (LIS) eligibility determination would be in the instance where an individual has specifically asked the State to make the determination. The Fair Hearing process followed would be the same as any eligibility appeal. To date the State has had no requests for LIS eligibility determination. (Refer to the attachment on the LIS policy)

DPHHS has no appeals process for complaints arising from drug plan administration; drug plans are governed by CMS. However, DPHHS will provide advise on where to go for help and information to dual-eligible individuals and MHSP/Medicare eligible individuals who may need assistance with complaints or appeals to a drug plan.

6. Please provide the work plan, goals, milestones, and progress in completing milestones to implement SB 324.:

The Health Resources Division is responsible for the design, development and implementation of SB 324. At this time, the division is working on the Big Sky Rx program (Medicare Prescription plan premium payment). The Department has formed

an advisory workgroup to assist in reviewing information, give guidance and provide feedback as the Department implements the program. Here is an update on the major components of the Big Sky Rx program:

- Rules: The rules are being drafted in order to implement the program and begin paying Medicare Drug Plans premiums effective January 2006. While the rules may be filed after November 1, 2005, they will be retroactively effective to November 1, 2005.
- Application: The application is in its final review process and we anticipate having the application completed and ready for distribution by the week of October 24th.
- Outreach Program: We are currently designing the outreach campaign and are working to coordinate it with the release of Medicare Prescription drug plan information.
- Enrollment: We are working with Northrop Grumman to design and implement an eligibility system necessary to enroll clients into the Big Sky Rx program in addition to other pharmacy assistance programs listed in SB 324. We are anticipating that the program can begin to enter accepted applications in mid-November (11/15) to coincide with the open enrollment of the Medicare drug plans.
- Staffing: We have hired one program manger and the outreach position. The position announcement for the eligibility workers has closed and interviews will be the week of October 17th with an anticipated start date of November 7th.

While SB 324 had many components, the Division is currently focusing on Big Sky Rx. The bill provided start-up costs solely for Big Sky Rx to ensure the program is operational effective January 2006 when the Medicare prescription drug coverage is implemented. The other programs: MT PharmAssist Program, Rx Discount Program, and Prescription Drug Education will be worked on after the additional funding is released. The release date is estimated to be around December 1, 2006.

7. What are the preliminary estimates of how many persons will be able to enroll in Montana Rx (SB 324) coverage for calendar year 2006?

The Department is anticipating enrolling approximately 20,000 Montanans into the program for calendar year 2006. The actual monthly premiums for the Medicare plans were released in late September 2005. We are currently reviewing the plans to set the monthly premium cap to ensure the program covers an appropriate number of plans and maximum enrollees. The number of people that are able to enroll in the program will vary based on the amount of premium for each eligible enrollee. The other programs passed in the bill affect the total appropriation because they will require funding in addition to the Big Sky Rx program. These program budgets will impact the number of enrollees who can be covered under the Big Sky Rx program.

8. Are state institutions (Montana State Hospital, Montana Mental health Nursing Care Center, Montana Developmental Disability Center, veterans' homes) part of a long-term pharmacy? If so, which one(s)? DPHHS has two contracts for institutional pharmacy: (1) McKesson handles the Montana State Hospital, Montana Chemical Dependency Center, Montana Developmental Center, and (2) Montana Mental Health Nursing Care Center has their contract with the local hospital in Lewistown. Both contracts state the pharmacy provider needs to bill at the Minnesota Multi-State Contracting Alliance for Pharmacy (MMCAP) price.

The Montana Veterans Home has a VA pharmacy on campus and receives drugs from Fort Harrison through a contract arrangement. We continue to work on how drugs can be provided in the least costly manner under Part D and still maximize reimbursement. We have had several discussions on the Medicare eligible veterans and how billing to Medicare part D can be accomplished by the facility. The VA cannot bill Medicare. We are the only state in the nation to have a VA pharmacy arrangement for veterans to receive lower cost drugs.

9. Will DPHHS provide a tool (web based or otherwise) to help person compare drug plans or will DPHHS provide a link to such a tool?

DPHHS can provide a link to the CMS medicare.gov's "Search Tools" web site where resources are located to assist individuals in making decisions relating to the prescription drug coverage.

10. How will DPHHS assist dual eligibles who are auto enrolled in a drug plan determine whether it is the correct plan for them?

The Medicaid program is specifically prohibited from assisting dual eligibles in determining which plan is correct for them. However, dual eligibles can seek assistance through the SHIP programs. As stated in a CMS guidance document (see attachment dated 9/21/05) "However, staff members of organizations providing enrollment assistance: (1) SHOULD NOT make recommendations about specific plans and (2) MUST clearly step back and allow people to make independent decisions."

DPHHS will send a letter to each dual eligible person in early December to let them know that their prescription drug benefit under Medicaid will end. We will also provide information in this correspondence that will help them evaluate the drug plan to which they've been assigned as well as resources for additional information.

We have also included a copy of the update relating to our plan to implement administrative duties for the Medicare Modernization Act, which provides further details relating to some of the questions above.

Attachments (4):
1. State Determination of Low Income Subsidy
2. Guidance for Organizations
3. CMS - Help is Here-Training Resources
4. LFC MMA Update

Cc:
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